

came from the Hastings Center (Briarcliff Manor, New York) in its 1987 *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*. These guidelines cover not only persons who are terminally ill but people with a "disabling condition that is severe and irreversible."^{5(p28)} They also make cost-worthiness a consideration in deciding whether to continue medical treatment.

The "slippery slope" image implies that the extension of assisted suicide to socially stigmatized persons would occur inadvertently, unconsciously, and unintentionally. That image conjures up the specter of a progression from euthanasia for only terminally ill persons to the coerced deaths of those who are devalued but not dying. But neither aspect of the metaphor accurately represents what has been happening. Although no state has yet adopted a euthanasia statute for terminally ill persons, advocates of such laws have pressed for court rulings to guarantee persons with major disabilities the "right" to physician-assisted suicide. In the Bouvia, McAfee, and Rivlin⁶ cases, courts in California, Georgia, and Michigan granted such requests. This is not an unintended slide down a slope. Suicides of disabled persons are already being socially and legally sanctioned.

The health care system and the courts must stop abetting the suicides of disabled persons. Three guidelines should be adopted:

- We must repudiate the notion that assistive devices and services for severely disabled persons are merely prolonging their dying. We must reject the argument that bids for assisted suicide by disabled persons are refusals of medical treatment. Equating disability with terminal illness reflects not a person's medical condition but their devalued social status.
- Persons with disabilities who request assisted suicide must be evaluated by professionals knowledgeable about the psychology of disability and the oppressive social experience of people with disabilities in this society. The misunderstanding of Larry McAfee, David Rivlin, and Elizabeth Bouvia by their psychiatric examiners demonstrates that evaluation by professionals with appropriate expertise is absolutely essential.
- Any body convened to discuss the euthanasia issue or to draft or apply rules governing the refusal of medical treatment must include representatives of the disability-rights community. Symposia to debate aid in dying commonly do not include discussants from that perspective. (This journal is a notable exception.) In the Bouvia and McAfee cases, the courts welcomed and even solicited the views of nonhandicapped persons but ignored the amicus briefs filed by disability-rights groups. No disability-rights leaders were included in the drafting of the Hastings Center guidelines. The disability-rights community has a distinctive perspective to contribute to this public debate. Given that the lives of people with disabilities are at stake, including that viewpoint is a matter of social justice.

PAUL K. LONGMORE, PhD
Visiting Assistant Professor
Department of History
Stanford University
Stanford, California

REFERENCES

1. *Bouvia v Riverside*, 159780 (Cal Super Ct 1984); *Bouvia v Superior Court*, 225 P2d 300-8
2. *State of Georgia v McAfee*, 385 SE2d 651
3. Society for the Right to Die: The Living Will. New York, NY, Choice in Dying, (formerly Society for the Right to Die and Concern for Dying), 1967

4. Girsh FJ: Physician aid in dying—What physicians say, what patients say. *West J Med* 1992 Aug; 157:188-189

5. Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying. Briarcliff Manor, NY, Hastings Center, 1987

6. Longmore PK: The strange death of David Rivlin. *West J Med* 1991; 154:615-616

The Popular Movement for Physician-Assisted Dying—What the Public Is Saying, What Physicians Are Hearing

SHORTLY AFTER Jack Kevorkian, MD, helped Janet Adkins kill herself in June 1990, a colleague and I wrote an article urging the profession of medicine to take seriously the increasing public voice asking for aid in dying.¹ It seemed to us that in the media furor following the first Kevorkian case, the "voice of the profession" was heard as a unitary one—rejecting thoroughly and unconditionally the idea of physicians helping people die as being immoral and inconsistent with medical ethics. We thought that the Kevorkian case was so bizarre as to obscure the more real-life cases that go on every day. We were also impressed by the consistency of the data showing that a majority of people in the United States favor policies that would allow them aid in dying when they are terminally ill, and they would prefer physicians to help rather than family members. In the face of this consistent public opinion, the rigid Hippocratic stance seems an inadequate response; we should at least be asking ourselves what this public debate means to our patients.

In the past two years, there has been much more open discussion within the medical profession, especially in the wake of an article by Timothy E. Quill, MD, in the *New England Journal of Medicine* describing his personal experience in physician-assisted suicide.² I hope that discussion will continue. Informal discussions among physicians make it clear that this practice is not a new one; it has probably been going on covertly in the intimacy of the doctor-patient relationship throughout the history of medicine. In a recent survey by the American Society of Internal Medicine, 20% of respondents said they had assisted a patient's dying in response to requests by the patient.³ In her commentary in this issue, Faye Girsh, EdD, says that younger physicians are increasingly accepting physician aid in dying as a patient's right,⁴ but in discussions with my colleagues, it seems that older physicians are much more likely to be flexible on this topic, particularly if they have cared for patients in the throes of terminal illness. It is the experience of many years that brings physicians in practice face to face with these important dilemmas. Younger physicians may be more likely to see the issue in black or white terms rather than in its thoroughgoing and extensive grayness.

In the past, these acts of mercy on the part of physicians were probably better kept cloaked within the privacy of the doctor-patient relationship. Modern medicine has lost the ability to conduct its work in that kind of silence, however. We are now called on to be accountable to the public for both standards of ethical practice and standards of competent medicine. In this context, in most states participation in physician-assisted dying is still illegal. It is unrealistic to ask physicians even in extreme and unusual circumstances to take the risk that breaking the law would entail. Interestingly, recent reviews of the law in this area suggest that in most cases—unlike the Kevorkian situation—where there is a long-standing doctor-patient relationship and where the physician is clearly acting with merciful motives, charges are always

dropped or sentences suspended. It is as if the law must assert its condemnation of killing and yet make an internal exception at the level of the judge and jury when these kinds of special cases arise. But in this new, open environment, it could be argued that policies should reflect what is actually happening rather than an idealistic but unrealistic standard. Real threats of abuse exist, and yet there is no reason to think that legalization will bring more abuse than allowing the practice to go on covertly.

The profession also should ask itself whether public insistence on aid in dying indicates other failings in the care of dying patients. Here we have a lot to learn, and should we be able to make progress, we could probably prevent a good deal of emotional anguish around terminal illness for both patients and their families. With the single exception of hospice care, the skills of which are not routinely taught in residency training or practiced in most acute care hospitals, the medical profession is woefully ignorant of and unable to conduct compassionate comfort care. Patients are therefore left to believe that their only choices are acquiescence to unrestrained life-sustaining technology or abandonment by their physician. With this kind of a choice, it is not surprising that people facing terminal illness might want some control over the time and manner of their demise.

Dr Girsh has made an important addition to this vigorous debate by her hypothetical dialogue between physicians and patients on this topic.⁴ She raises many of the most common objections we hear from physicians on this topic and presents thoughtful responses that I hope will stimulate discussion among physicians' groups on medical staffs of hospitals, in practice, and in specialty societies.

This editorial was written while Dr Cassel was a fellow at the Center for Advanced Study in the Behavioral Sciences, Stanford, California, where her work was supported by a grant from the Henry J. Kaiser Family Foundation.

CHRISTINE K. CASSEL, MD
Chief, Section of General Internal
Medicine
Division of Biological Sciences
University of Chicago
Pritzker School of Medicine
Chicago, Illinois

REFERENCES

1. Cassel CK, Meier DE: Morals and moralism in the debate on euthanasia and assisted suicide. *N Engl J Med* 1990; 323:750-752
2. Quill TE: Death and dignity: A case of individualized decision making. *N Engl J Med* 1991; 324:691-694
3. Crosby C: Internists grapple with how they should respond to requests for aid in dying. *Internist* 1992 Mar, p 10
4. Girsh FJ: Physician aid in dying—What physicians say, what patients say. *West J Med* 1992 Aug; 157:188-189

Death, Politics, and Philosophy

CONSTANT MEDITATION on death is good for the soul, said our religious forebears. The citizens of Washington State meditated on death recently but not constantly. They meditated only long enough to decide how they would vote on Initiative 119, which would have authorized physicians "to effect the death of a patient in a dignified and swift manner." November 5, 1991, brought voters to the polls to vote on three eternal verities: death, as in euthanasia and abortion; taxes; and the perfidy of politicians. After brief meditation, they affirmed by a close vote a woman's right to abortion and negated a patient's right to choose aid in dying. In so doing, they decided that Washington State would not become the first jurisdiction in the world to make active euthanasia legal.

The prepoll meditation on death convinced more voters to mark no rather than yes, even though earlier surveys had

indicated the opposite. Why they did so is uncertain: Proponents claim mendacious television advertising—of which they were not themselves innocent—misled voters to believe there were no safeguards against abuse. Perhaps the gruesome exploits of Jack Kevorkian, MD, who aided two women to die several days before the election, turned the voters' hearts away from merciful death. More likely, many voters realized that "death with dignity," the title of the initiative, was not the issue but that an unprecedented legal authorization of the healing profession to take life was. They were unready to grant that authority.

This was wise, for they were persuaded that the proposed amendments to state law did not have adequate safeguards against abuse. Although literally limited to voluntary patients who were terminally ill and who competently requested their physicians to end their life, the law seemed to insulate this decision so tightly from oversight and scrutiny that the slippery slope lurked ahead. Who would know whether a less-than-competent patient had been aided to die because they "would certainly have asked for help, had they been able"?

The proponents of Initiative 119 denied the opponents' allegation that the law afforded only weak protection against abuse. At the same time, their colleagues in the Hemlock Society offered legislation in California that added several of the safeguards critics found lacking in the Washington proposal. When the issue comes to the voters again, whether in California, Washington, or elsewhere, it will be more difficult for the opponents to defeat. The safeguards whose absence they criticized will be included. Opponents will have to move to a more philosophical and less easily argued plane.

The arguments will circle around the questions and answers stated so eloquently by Faye Girsh, EdD, in this issue of the journal.¹ I say "circle" because around each of her statements stands a set of arguments that can become deeply philosophical and, if you will, theological. These sorts of arguments are difficult to pose and to follow, even for persons adept at philosophy and theology. They certainly are not reducible to the infamous sound bites that suck all the substance out of important ideas. Still, in the long run, each of us, considering and appreciating the arguments as best we can, must come to a personal judgment.

During the political campaign in Washington State, I was an opponent of Initiative 119. My opposition stemmed largely from the public policy and legal drafting problems that I saw in the initiative. As a professor of medical ethics, I also have what I think are deeper philosophical objections. Yet I must admit that as we debated, I found my philosophical objections becoming somewhat less persuasive and the propositions of those philosophers and ethicists who favor active voluntary euthanasia becoming more plausible. A month after the election, I attended a small conference of ethicists and physicians, sponsored by the Kennedy Institute of Georgetown University (Washington, DC) and the Johns Hopkins School of Medicine (Baltimore, Maryland), where I heard discussions on the highest philosophical plane that left me wondering even more about my previously firm opposition.

Then, a few weeks later, the political debate and the philosophical arguments turned personal. I sat by the side of a dying relative very dear to me. At age 90, he was simply wearing out. A proud, fastidious, and philosophical man, he had been reduced in several weeks to incoherence, incomprehension, and incontinence. Not in great pain, he was clearly uncomfortable and restless. A physician himself for more